Indiana Department of Education
SUPPORTING STUDENT SUCCESS

Medical Necessity Guidance: 2012-13 Assessments

Introduction

Medical Necessity Requests are completed for students with medical conditions covered by the Americans with Disabilities Act and/or Section 504 of the Rehabilitation Act that prohibit them from successfully participating in an accountability assessment. ***Any participation exemption granted by the Office of Student Assessment is limited to the particular testing window for which it was requested.***

A request will be considered for a Medical Necessity that meets the below listed requirements. Examples include, but are not limited to:

- The student has a serious, ongoing illness or chronic condition that has lasted or is expected to last at least 6 months or has acquired at least one cumulative month of absences or hospitalization.
- The student's illness or chronic condition requires daily, ongoing treatments and monitoring by appropriately trained personnel.
- The student's condition requires medical care but does not necessitate daily treatment by a health care provider, and the student's medical condition prohibits participation in the assessment.

Required Documentation

A request for exemption must be accompanied by a signed statement from the student's treating physician that 1) describes the nature of the ongoing or chronic condition; and 2) confirms that the condition has substantially prevented the student from accessing educational services.

Process

Local

- The school corporation superintendent (or Nonpublic/Charter/Choice school principal) shall discuss the request with school personnel and determine whether the student has met the criteria for a medical necessity exemption during the specific testing window.
- If the superintendent (principal) supports the request, **the form on page 2 of this document must be submitted on or before the date indicated below (based on a particular testing window)**, to the Office of Student Assessment **via fax at 317-233-2196**.

  Emergency exceptions may apply for students who have unexpected but ADA/Section 504-covered conditions that prevent participation in an assessment. Please contact the Office of Student Assessment for such situations.

  - **IMPORTANT Note:** A signed statement from the student's treating physician describing the nature of the chronic condition **must accompany the request**.

Submit a ***Medical Necessity Request Form*** for the appropriate testing window (form due date appears after each window). *Additional copies of the form must be submitted if more than one request is needed.*

Assessment	Form Due	Assessment	Form Due
ISTEP+ App Skills	February 4, 2013	**LAS Links**	December 19, 2012
ISTEP+ M/C	April 1, 2013	**ECA-Fall**	September 24, 2012
IMAST	April 1, 2013	**ECA-Early Winter**	November 12, 2012
ISTAR	February 1, 2013	**ECA-Late Winter**	January 14, 2013
IREAD-3 – Spring	February 18, 2013	**ECA-Spring**	March 25, 2013
IREAD-3 – Summer	TBA	**ECA-Summer**	May 23, 2013

- Upon receipt of the request form and the physician's statement, an email will be sent confirming receipt.

IDOE

- The Director of Student Assessment will ensure review of requests.
- The results of the review will be communicated to schools/corporations approximately two weeks after receipt of the Medical Necessity request.

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Medical Necessity Request Form: 2012-13 Assessments

Select ONE testing window *(form **due date** appears after each window)*:

- ☐ **ISTEP+ App Skills** (February 4, 2013)
- ☐ **ISTEP+ M/C** (April 1, 2013)
- ☐ **IMAST** (April 1, 2013)
- ☐ **IREAD-3 – Spring** (February 18, 2013)
- ☐ **LAS Links** (December 19, 2012)
- ☐ **ISTAR** (February 1, 2013)
- ☐ **ECA-Fall** (September 24, 2012)
- ☐ **ECA-Early Winter** (November 12, 2012)
- ☐ **ECA-Late Winter** (January 14, 2013)
- ☐ **ECA-Spring** (March 25, 2013)
- ☐ **ECA-Summer** (May 23, 2013)

Additional copies of the form must be submitted if more than one request is needed per student.

1) Date of Request: _____

Corporation Name and Number: _____

School Name(s) and Number(s): _____

CTC Telephone Number: (_____) _____

Email Address: _____

Student Name: _____

Date of Birth: _____

STN: _____

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2) Briefly describe the student's medical condition related to this request:

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3) ***Superintendent or Nonpublic/Charter/Choice School Principal to Complete this Section:***

By signing below, I affirm that the information provided can be verified at the request of the Indiana Department of Education.

Signature: _____ **Date:** _____

Print Name: _____

IMPORTANT: Be sure to submit the **physician's statement** along with **this form *on or before the date indicated based on the testing window***, to the Office of Student Assessment **via fax at 317-233-2196.**

If you have questions, please contact **Karen Stein**, Special Programs Assessment Specialist, via email at kstein@doe.in.gov or by calling 317-232-9050.

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FOR IDOE USE ONLY

_____ **Approved** _____ **Not Approved** **Date:** _____ **Initials:** _____

Assessment Director Signature: _____ **Date:** _____